DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

4JH = 5/3

PRINTED: 04/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445186	A. BUILDING _____ B. WING _____	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTH CARE	902 BUCHANAN RD NEW TAZEWELL, TN 37825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F 225E** Resident #72 and #122 were observed And interviewed by Social Worker, No indications that further action was needed. Both residents are doing well. All incidents for past 12 months were reviewed by Director of Nursing and No additional incomplete investigations were found. All staff members were educated to pro-actively Write witness statements at any time They have knowledge of a situation that could be an allegation of abuse, or if They have witnessed an incident involving Any/ and All residents. These education sessions scheduled between March 23-and April 18, 2014. All 24 hour shift reports will be reviewed by Director of Nursing or Designee. & all incidents will be reviewed by Facility Management team daily during the Morning meeting, weekly in the Focus meeting, and monthly during the facility QAPI committee meeting, attended by The Administrator or Proxy, Director of Nursing or Proxy, Medical Director, Staff Development Director and Social Worker, To ensure all investigations are complete.	4/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 4-9-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LAUREL MANOR HEALTH CARE	802 BUCHANAN RD NEW TAZEWELL, TN 37825

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, review of facility policy, observation, and interview, the facility failed to perform a complete investigation related to an allegation of abuse for two residents (#72, #122) of four residents reviewed for abuse investigations. The findings included: Resident #72 was admitted to the facility on July 3, 2013, with diagnoses including Muscle Weakness, Bipolar Disorder, Coronary Artery Disease, Hypertension, Diabetes Mellitus and late effect Hemiplegia (paralysis). Medical record review of the quarterly Minimum Data Set (MDS) dated October 2, 2013, revealed the resident scored a twelve on the Brief Interview for Mental Status (BIMS), indicating the resident was moderately cognitively impaired; required extensive assistance with the activities of daily living; required limited assistance with locomotion; and no behaviors were observed. Medical record review of a nurse's note dated December 8, 2013, at 12:31 a.m., written by Licensed Practical Nurse (LPN) #1, revealed, "...resident sitting in lighthouse dining area when another male resident came up to...and slapped...in the face...resident has a pain scale of zero...family was notified...color within normal limits...respirations even and unlabored...no acute distress noted at this time..." Medical record review of a nurse's note dated December 9, 2013, at 2:30 p.m., written by LPN	F 225		

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F 225	Continued From page 2 #1, revealed, "...resident-resident (resident-to-resident) altercation was not witnessed by nursing staff...female resident reported altercation..." Medical record review of a Social Service Director (SSD) note dated December 9, 2013, at 2:51 p.m., revealed, "...nursing reported that (resident #72) has been experiencing confusion...reporting an altercation with a male resident that wasn't witnessed by staff as well as no injury...(resident) currently resides in the Light House (locked unit) with a diagnosis of Simple Schizophrenia and Bipolar...has difficulty with memory recall..." Further review revealed, "...I met (resident) in the Light House regarding above...resident reported...had been sleeping and no one has bothered me...there is no change in...normal routine...no signs/symptoms of emotional distress..." Medical record review of a general note dated December 9, 2013, at 5:22 p.m., written by Registered Nurse (RN) #1, who is the Risk Manager (RM), revealed, "...staff reported that resident has had increased confusion and agitation at this time...referral made for Psych services to evaluate and treat as indicated...altercation was not witnessed by staff and no injury noted to resident...no occurrences reported by (resident #72) at this time, resident reported that...was fine..." Review of facility documentation dated December 9, 2013, written by the SSD and signed by the RM, revealed, "...approximately 2:30 p.m., (RM) and I spoke with (LPN #1), regarding resident to resident altercation that (LPN #1) had documented in nurse's notes...upon discussion	F 225		

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F 225	Continued From page 3 with (LPN #1)...reported that the LPN didn't witness anything...when asked if...heard anything, the LPN reported that...did not hear anything as well...the LPN confirmed that...did not assess the male resident..." Review of a 24 Hour Report-Change of Condition Report dated December 8, 2013, revealed on the 10:00 p.m. to 6:00 a.m. shift "...(resident #72)...incident...(resident #122)...incident..." Review of the Abuse Policy #N-A-045 dated March 1, 2014, revealed, "...all investigations shall be conducted by the Administrator, Director of Nursing (DON) or subject matter expert...the investigation shall include interviews of employees, visitors, volunteers and vendors who may have knowledge of the alleged incident..." Further review revealed, "...written statement from involved parties should not be requested as all information will be documented on the investigation form or a state required form..." Further review revealed, "...federal law requires the center to have evidence of investigations of alleged violations..." Observation on March 18, 2014, at 3:00 p.m., revealed the resident in the hallway walking without assistance and no behaviors were observed. Observation on March 19, 2014, at 10:00 a.m., in the resident's room, revealed the resident sitting on the bed and no behaviors were observed. Interview with resident #72 on March 17, 2014, at 3:39 p.m., in the resident's room, revealed, "...was in the locked unit and a male smacked me in the mouth...I told the nurse...not sure what was	F 225		

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F 225	Continued From page 4 done..." Interview with LPN #1 on March 18, 2014, at 2:00 p.m., in the nurse's station, revealed, "...was working the night shift on December 8, 2013, on the Light House wing...I heard a smack and one of the aides (Certified Nursing Assistant) came into the room...we saw (resident #72) and (resident #122) in the room...(resident #72) had a red area noted on the chin and the resident stated the other resident hit...I did not see the incident...just heard the smack..." Further interview revealed, "...I assessed the resident for pain and (resident #122) walked out of the room..." Continued interview revealed, "...I filled out an investigative report regarding the incident and left the report under (the RM) door...the next shift was made aware of the incident which was forwarded to the unit management..." Interview with the SSD on March 18, 2014, at 2:40 p.m., in the SSD office, revealed, "...spoke with the resident who reported to me no one had bothered me...I went ahead and followed the resident...I saw the resident on December 9, 2013, and December 11, 2013..." Interview with the RM on March 18, 2014, at 2:50 p.m., in the conference room, revealed there was no investigative report related to the allegation. Further interview revealed, "...I interviewed the resident and the resident stated nothing happened...I was not aware there was a Certified Nurse Assistant (CNA) who witnessed the incident...I did not interview the CNA..." Telephone interview with CNA #1 on March 18, 2014, at 4:35 p.m., revealed the CNA was working on the Light House Unit on December 8,	F 225		

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F 225	Continued From page 5 2013. Further interview revealed, "...was in another resident's room...I did not witness the incident...came up the hall and went into the dining room...(resident #122) was walking out of the dining room where (resident #72) was sitting..." Further interview revealed, "...(resident #72) stated that (#122) had slapped...in the face...I do not recall the resident's face being red...all I heard was yelling..." Further interview revealed, "...(LPN #1) was at the nurse's station and I went and got the LPN...it was just me and LPN on the unit that night..." Continued interview revealed, "...was never interviewed regarding the incident..." Interview with the RM on March 19, 2014, at 10:45 a.m., in the conference room, revealed the RM and SSD interviewed LPN #1 on December 9, 2013, and counseled the nurse regarding documentation of factual allegations and any potential injuries related to the incident. Further interview confirmed resident #72 made the allegation of abuse to LPN #1 and CNA #1. Further interview confirmed the facility's investigative form could not be located and CNA #1 was not interviewed after the allegation by the resident. Resident #122 was admitted to the facility on November 14, 2013, with diagnoses including Senile Dementia, Chronic Airway Obstruction, and Muscle Weakness. Medical record review of the Quarterly Minimum Data Set (MDS) dated November 10, 2013, revealed the resident was severely cognitively impaired; required extensive assistance with activities of daily living; required limited assistance with locomotion; had no behavioral	F 225		

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F 225	Continued From page 6 symptoms; and exhibited wandering one to three days weekly. Medical record review of the nursing notes dated December 8, 2013, revealed, "female resident sitting in dining area when resident slapped...in the face..." Continued review of a nursing note dated December 9, 2013, revealed, "...clarification...resident to resident altercation not witnessed by nursing staff...altercation was reported by female resident..." Interview with LPN #1 on March 18, 2014, at 3:00 p.m., in the secure unit nursing station, revealed LPN #1 reported on December 8, 2013, on the third shift, the nurse "heard a noise" from the secure unit dining room, and upon investigating the source of the noise a female resident in the dining room reported resident #122 had slapped the resident. Continued interview revealed LPN #1 reported the female resident was not injured, but upon examination the resident's chin was red in color. Continued interview revealed LPN #1 stated a facility incident report was completed after the two residents were separated and assessed, and placed under the RM's door at the end of the shift. Continued interview revealed LPN #1 made an oral report to the oncoming first shift nurse the following morning. Continued interview with LPN #1 revealed the nurse did not recall being interviewed by the facility RM or abuse coordinator in relation to the incident. Interview with the facility RM, on March 18, 2014, at 3:15 p.m., in the hallway of the secure unit, revealed the RM reported no copy of a facility document was received related to the event. Continued interview revealed the incident was investigated by the facility Social Services	F 225		

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F 225	Continued From page 7 Director (SSD) after the incident was discussed in a morning meeting on December 9, 2013. Interview with the SSD on March 18, 2014, at 4:15 p.m., in the social services office, revealed the SSD had not been made aware of LPN #1's statements the female resident had a red chin upon examination during the SSD investigation of the incident. Continued interview revealed the SSD did not recall if any facility documents were completed in relation to the alleged incident. Continued interview revealed the SSD was unable to interview resident #122 as the resident was severely cognitively impaired. Continued interview revealed during SSD's investigation, the female resident was interviewed, did not recall any occurrence of being slapped, and did not exhibit symptoms of psychological duress. Continued interview revealed the SSD did not interview LPN #1 or other clinical staff who were present on the unit when the alleged incident occurred. Interview with the facility RM, on March 18, 2014, at 4:30 p.m., in the conference room, confirmed the facility could not produce facility documents allegedly completed by LPN #1 in relation to the incident. Continued interview confirmed the alleged incident was discussed in a morning meeting by the facility nursing management prior to the Social Services Director's investigation of the alleged incident. Continued interview confirmed LPN #1 and the Certified Nursing Assistant (CNA) on duty at the time of the alleged incident were not interviewed in relation to the alleged incident. Continued interview confirmed the facility investigation of the alleged incident was not thorough.	F 225		

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F 226	Continued From page 8	F 226	**F 226 D**	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to notify the Administrator in a timely manner for an injury of unknown origin as required per the facility's policy for one resident (#31) of four residents reviewed for abuse. The findings included: Resident #31 was admitted to the facility on September 8, 2005, with diagnoses including Severe Osteoporosis, Dysphagia, Psychosis, Senile Dementia, and Diabetes. Medical record review of the Quarterly Minimum Data Set (MDS) assessment dated January 13, 2014, revealed the resident had short and long term memory deficits, and moderate cognitive impairment effecting skills for daily decision making. Continued review revealed the resident required extensive assist of two persons for bed mobility, dressing, and personal hygiene. Continued review revealed the resident was dependent on two persons for transfers and toileting. Observation of the resident lying in bed on March	F 226	No corrective action was required For Resident #31, as failure to notify Administrator did not impede the investigation process for the injury Of unknown cause, that was initiated And conducted by Staff Rn and Director of Nursing. Event reports that involve residents Were reviewed by Director of Nursing, And all other reports indicate Administrator Was notified appropriately per policy 4/7/14 All Staff were Re-trained regarding facility Policy that requires Administrator to be Notified immediately of Events involving Residents that could be abuse, or injury of unknown origin. Quarterly review of Abuse prevention policies and Procedures Will be required by full time staff provided In the facility Electronic Education Silver-Chair program. All other staff will receive Abuse Prevention Policy and procedure In Classroom review conducted by Staff Development Director at least annually. Education review of policy and procedure Regarding Abuse prevention, will be Monitored by the facility Staff Development Director quarterly and reported to facility QAPI committee that is attended by Administrator or proxy, Director of Nursing Or Proxy, Medical Director or proxy, Staff Development Director, Social Worker.	4/30/14

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F 226	Continued From page 9 17, 2014, at 3:14 p.m., revealed the resident had a wrap-type bandage around the left hand and a splint over the left thumb. Continued observation revealed the thumb was dark purple in color, and the skin on the ball of the hand, not covered by the wrap, was also dark purple in color. Medical record review of the nurse's note dated March 15, 2014, at 10:27 a.m., revealed, "I was called to resident's room this morning to assess a large bruise and swelling to left thumb. Resident is unable to verbalize what happened...no outward signs of pain noted. Mobilex notified of need for x-ray. Dr.(doctor)...notified...No other areas of concern are noted at this time." Medical record review of an X-ray dated March 15, 2014, revealed the resident had severe osteoporosis and a comminuted fracture involving the proximal phalanx of the thumb. Review of the facility's policy, Abuse Policy, revealed, "Purpose: Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property...It is the policy of the center to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations") are reported immediately to the Administrator of the center..." Interview with the Administrator on March 19, 2014, in the Administrator's office at 10:20 a.m.,	F 226		

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F 226	Continued From page 10 confirmed the injury of unknown origin had occurred on March 15, 2014, and the Administrator had not been made aware of the injury until March 17, 2014.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide assistance in a manner to promote dignity for one resident (#21) of twenty-nine residents reviewed. The findings included: Resident #21 was admitted to the facility on February 4, 2014, with diagnoses including Muscle Weakness, Malignant Neoplasm of the Lung, Atrial Fibrillation, Anxiety, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus. Medical record review of the Admission Minimum Data Set (MDS) assessment dated February 11, 2014, revealed the resident scored three out of fifteen on the Brief Interview for Mental Status assessment indicating severe cognitive impairment. Continued review revealed the resident required extensive assistance of two persons for transfers, and activities of daily living, and the assistance of one person for eating.	F 241	**F 241** Resident #21 has been observed at random times over 7 days following survey, and has not exhibited any negative impact from improper feeding technique. The Nurse Aide involved was removed from feeding team until she was re-educated on proper feeding technique for respecting resident's dignity. All residents that require feeding has Been observed by Director of Nursing And Social Worker at Random mealtimes And no other inappropriate feeding Techniques were observed. All Staff attended training sessions for Review of appropriate feeding techniques to promote dignity for all residents. All Managers were trained to observe during Meals for continued compliance. Director of Nursing and Nurse Managers Will observe staff feeding techniques at random mealtimes and report findings to QAPI committee monthly x 3 months the meeting to be attended by Facility Administrator or designee, Director Of Nursing or designee, Staff RN, Social Worker, and Medical Director or designee.	4/30/2014

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F 241	Continued From page 11 Observation at mealtime on March 17, 2014, at 12:30 p.m., of multiple residents seated in the day room on the 200 hallway, revealed resident #21 seated in a geri-chair next to a loveseat. Continued observation revealed the Certified Nurse Assistant (CNA) #2 set the resident's tray on the loveseat, then sat on the arm of the loveseat, and fed resident #21 from the plate propped on CNA #2's lap. Interview with Licensed Practical Nurse #2, at this time, confirmed CNA #2 should have been seated to assist the resident with eating. Continued interview confirmed assisting the resident with eating in this manner was not correct. Interview with the Director of Nurses, on March 19, 2014, at 8:41 a.m., in the Activities Room, confirmed to promote dignity during mealtime, the facility's expectation would be for staff assisting residents with eating to be seated on the same level as the resident.	F 241		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to minimize odors on one of three hallways.	F 252	**F 252 D** Resident # 131 will be transported to her scheduled surgical appointments Until wound is completely debrided and The odor from the wound is alleviated Meanwhile the nurse management team Will insure that the charcoal air filtering unit will be used in residents room consistently, checked off on 24 hour shift reports by every nurse assigned to resident #131 on all shifts through (Continued next page)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446156	A. BUILDING _____ B. WING _____	03/19/2014

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F 252	Continued From page 12 The findings included: Observation on March 17, 2014, at 9:50 a.m., during initial tour, revealed the presence of a foul odor outside resident #131's room on the harbour hallway. Continued observation revealed the odor was present throughout the harbour hallway. Continued observations on March 17, 2014, at 10:30 a.m., and again at 12:20 p.m., revealed the presence of the foul odor throughout the harbour hallway outside resident #131's room. Observation of wound care for resident #131, on March 19, 2014, at 2:30 p.m., revealed the resident had an open abdominal wound with blackened necrotic tissues and a foul odor being emitted from the wound. Continued observation revealed an electrically powered air purifier with charcoal filters present in the resident's room. Continued observation revealed the air purifier was unplugged from the electrical outlet. Interview with the housekeeping director, on March 17, 2014, at 12:20 p.m., in the harbour hallway outside resident #131's room revealed the odor in the hallway had been present "for several days." During continued interview the housekeeping director revealed, "...the nurses had placed a machine in the room to keep the odor down, but it was not working..." During continued interview, the housekeeping director confirmed the presence of the foul odor throughout the harbour hallway and confirmed the facility had failed to maintain hallways free from odors.	F 252	F 252 D (Continued) Residents in close proximity of Resident #131's room was interviewed on March 20, 2014 and April 3rd, 2014 To determine if environment was free of odors- 100% of residents interviewed indicated that the environment was odor free. Observation by Housekeeping Supervisor And Staff Nurses at random times within a 24 hour periods for several days after the survey determined that environment was odor free 100%. Nurses assigned to the area around resident #131's room will be responsible for checking The air filtering equipment in residents room To insure equipment is turned on and working Properly, and the environment is odor free On each tour of duty. Housekeeping manager or designee will check Resident #131's room to double check that Equipment is turned on and working properly, that environment in and around resident #131's Room is odor free on a daily basis until residents wound is healed. Director of Nursing or designee will perform daily monitoring of that section of Harbor Side for compliance. Reports of all findings will be reported in the facility morning meetings and to the facility QAPI committee meeting attended by Administrator or designee, Director of Nursing or designee, Medical Director or Designee, Social Worker, and Staff Nurse	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		4/30/2014

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F 279	Continued From page 13 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive care plan for urinary incontinence for one resident (#90) of three residents reviewed for urinary incontinence. The findings included: Resident #90 was admitted to the facility on May 14, 2012, with diagnoses including Muscle Weakness, Late Effects of Cerebrovascular Accident, Senile Dementia, Psychosis, Epilepsy, and Schizophrenia.	F 279	**F 279 D** Resident # 90's Care Plan was updated To indicate that the resident uses Protective undergarments for Incontinence On March 19, 2014 when this omission was identified. All other residents that have Care plan for Incontinence were reviewed to insure all Elements of Incontinent care management were identified in the Incontinence Care Plan. No other problems were identified. The MDS coordinator will review all Care Plans for residents that are being managed for incontinent care on a quarterly basis, for compliance. MDS Coordinator will report Care Plan reviews Completed on a monthly basis and findings to the facility QAPI committee monthly that is attended by facility Administrator or proxy, Director of Nursing or Proxy, Medical Director Or designee, Social worker, Staff RN, and MDS Nurses.	4/30/2014

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F 279	Continued From page 14 Medical record review of the Quarterly Minimum Data Set (MDS) assessment dated January 4, 2014, revealed the resident scored five of fifteen on the Brief Interview for Mental Status, indicating severe cognitive impairment. Continued review revealed the resident was occasionally incontinent of bladder, and required extensive assistance of one person for transfers, ambulation, personal hygiene, and toileting. Medical record review of the resident's care plan dated January 5, 2014, revealed the facility had not developed a care plan to manage the resident's urinary incontinence. Medical record review of the resident's bladder assessment dated January 7, 2014, revealed the resident was incontinent of bladder and used pads/briefs to manage incontinence. Interview with Registered Nurse/Unit Manager (RN) #1 on March 19, 2014, at 1:15 p.m., on the secured unit, confirmed the resident was incontinent of bladder and wore incontinence briefs to manage incontinence. Interview with the Assistant Director of Nursing, in the MDS office, on March 19, 2014, at 1:20 p.m., confirmed the facility failed to develop a care plan for managing the resident's urinary incontinence.	F 279		